U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 June 2007

In the Matter of:

C.W.,
Claimant

Case No.: 2005-BLA-05213

v.

EASTERN COAL CORPORATION,
Employer

THE PITTSTON COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

William Lawrence Roberts, Esq.
Pikeville, Kentucky
For the Claimant

Lois A. Kitts, Esq.
Baird & Baird, PSC
Pikeville, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C.

§ 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim December 6, 2005, in Pikeville, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness at the hearing. Transcript ("Tr.") 19-23. Director's Exhibits ("DX") 1-32, Claimant's Exhibits ("CX") 1-10, and Employer's Exhibits ("EX") 1-5, 7-9, and 11-18 were admitted into evidence without objection.[1] Tr. 6, 14, 17. The Claimant objected to proposed EX 6 and 10, depositions taken within 20 days of the hearing or, in the alternative, sought leave to file rebuttal evidence. Tr. 15-17. I ruled that the deposition transcripts would be admitted, and the record was held open after the hearing to allow the parties to submit additional evidence and argument. I hereby admit EX 6, the deposition of Dr. Broudy submitted by the Employer after the hearing, and CX 11, rebuttal by Dr. Hussain, submitted by the Claimant after the hearing. The Claimant and the Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits unless otherwise noted, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on September 2, 1988. The claim was finally denied after a request for modification by the Benefits Review Board on March 29, 2002, which affirmed the decision by Administrative Law Judge Joseph E. Kane that the Claimant had failed to establish either that he had pneumoconiosis, or that he was totally disabled by a pulmonary or respiratory impairment. DX 1. The Claimant did not appeal that determination. However, the Claimant attempted to withdraw his initial claim and file a new claim less than one year after the Board's denial. After an initial determination that the Claimant had withdrawn his claim, the District Director of the Office of Workers Compensation Programs ("OWCP") reversed his position and found that he did not have the authority to allow the Claimant to withdraw the claim. The Claimant stated that he did not wish to request modification on the prior denial, and the District Director then closed the file on the initial claim. The Claimant then refiled his new claim after the one-year period for a request for modification expired. *See* DX 1, 3.

The Claimant filed his current claim on July 17, 2003. DX 3. The District Director of the Office of Workers Compensation Programs issued a proposed Decision and Order denying benefits on August 9, 2004. DX 24. The Claimant appealed on August 17, 2001. DX 26. The claim was referred to the Office of Administrative Law Judges for hearing on November 9, 2004. DX 30.

[1] Initially the Employer objected to what appeared to be multiple medical reports offered by the Claimant, but the objection was resolved when it became apparent that many of the exhibits the Claimant was offering were treatment records, which are not subject to the limitations on medical evidence, rather than "medical reports," defined in the rules at 20 CFR § 725.414(a)(1), which are subject to the limitations. All exhibits offered by both parties were admitted, subject to post-hearing confirmation that the limitations had not been exceeded. Tr. 13-14, 17.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on July 17, 2003. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer, or by the Employer and the Director, are:

1. Whether the claim was timely filed.

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

5. Whether his disability is due to pneumoconiosis.

6. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2006).

DX 30; Tr. 4-6. The Employer withdrew the issues of whether the Claimant was a miner, post-1969 employment as a miner, and the number of years he was employed as a miner. The Claimant and the Employer stipulated to 24.5 years of coal mine employment. Tr. 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant was 61 years old at the time of hearing. He is married and has no dependent children. Tr. 19. He has an eighth-grade education. DX 3.

The Claimant testified that he worked in or around coal mines for 27 years. Tr. 20. The parties stipulated to 24.5 years of coal mine employment, as they had at the hearing on the

Claimant's prior claim. The Claimant worked at the cut machine, as a loader, and his last job was a "Jeffrey loader remote control." These jobs required him to lift heavy objects and exposed him to coal mine dust. He left the coal mines in August 1988 because his doctor at the time, Dr. Chericuri, advised him to do so because he was having trouble with his breathing. Tr. 20, 21. His last coal mine employment was in Kentucky. DX 6. Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Dr. Hussain is the Claimant's current treating physician for his breathing problems. He sees Dr. Hussain approximately once a month. Tr. 20-21. Over the years, he has been hospitalized for his breathing problems, which include wheezing, difficulty breathing, and coughing. He is on several medications, including inhalers and a nebulizer machine. Tr. 21-23. He has not been approved for supplemental oxygen at home, although he has been given oxygen several times. Tr. 22.

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. *See Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608 (6th Cir. 2001) ("[t]he three-year limitations clock begins to tick *the first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis.") (Emphasis in original). 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The Claimant was not asked at any of the hearings held on his claims (in 1990, DX 1 at 1681, *et seq.*, in 1995, DX 1 at 1314, *et seq.*, in 2000, DX 1 at 401, *et seq.*, or in 2005) whether or when a doctor has told him he is totally disabled due to pneumoconiosis. There is insufficient evidence in the record to establish that he has ever been told that he is totally disabled by pneumoconiosis. At most, it appears that he was told that he should stop working because he could not breathe, or because of a combination of problems. *Compare* his Social Security disability award, DX 1 at 109-114, his current claim, DX 3 at 1, and his work history, DX 5 at 2. Although he said during his 2002 deposition that black lung was the only cause for his lung problems as far as he knew, DX 1 at 18, I do not find that to be sufficient to invoke the statute of limitations. The Employer has offered no evidence or argument on this issue. I find that the presumption has not been rebutted, and the claim is timely.

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The first determination must be whether the Claimant has established with new evidence that he suffers from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such an impairment, none of the elements previously decided against him can be established and his claim must fail because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. 20 CFR § 718.204(a) (2006); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3d Cir. 1995). As will be

discussed in detail below, the medical evidence filed in connection with his current claim does not establish that the Claimant has pneumoconiosis or any other pulmonary or respiratory impairment which is totally disabling. Thus, I find that he has not established that a change in one of the applicable conditions of entitlement has occurred. It follows that I do not need to address the evidence in the record from his previous claims in explaining my decision that he is not entitled to benefits.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the admissible x-ray findings relied upon by the parties in connection with the current claim. X-ray interpretations submitted by the parties in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records are not subject to the limitations. X-ray readings in excess of the limitations do not appear on the table. *See* note 2 below.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Qualifications of physicians who read x-rays in connection with the black lung claim appear after their names. Qualifications of physicians are abbreviated as follows: B=NIOSH-certified B reader; BCR=Board certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/01/03[2]			CX 1 Younis Linear atelectasis right middle lobe.
08/19/03		**DX 11, DX 12** **West BCR, B** **EX 12 Wiot BCR, B**	DX 13 Barrett BCR, B Read for quality only Quality 1 (Good)
08/05/04			CX 2 Michaels Two views. Mild COPD with no acute process.
01/07/05			CX 4 Michaels Two views. Mild COPD with no acute process.
02/03/05	**CX 5 CX 9 Baker B** **ILO Classification 1/0**	**EX 7 Rosenberg B** **ILO Classification 0/0**	
05/11/05		**EX 1 Broudy B** **ILO Classification 0**	
07/18/05			CX 6 Michaels Two views. Minimal COPD with no acute process.
O9/02/05			CX 8, CX 10 Michaels Two views. Mild COPD with no acute process.

[2] The Employer introduced readings of this x-ray, and also of the x-rays taken on August 15, 2003, June 1, 2004, and January 7, 2005, by Dr. Poulos. EX 14. These x-rays were either taken in connection with the Claimant's treatment, in which case the Employer is not entitled to rebut them, *Henley v. Cowing & Co.*, BRB No. 05-0788 BLA (May 30, 2006) (unpub.), or otherwise exceed the evidentiary limitations, and the Employer did not show good cause why they should be admitted. For this reason, Dr. Poulos' readings do not appear on the table, and I have not considered them.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991).

CT scans were taken of the Claimant's chest as part of the examinations on behalf of the Employer by Dr. Rosenberg on February 3, 2005, *see* EX 11, and Dr. Broudy on May 11, 2005. The original report of the CT scan taken for Dr. Broudy does not appear anywhere in the record. According to the other reports, however, both CT scans were negative for pneumoconiosis. The Employer introduced an additional reading of the February 2005 CT scan by Dr. Wiot, EX 13. However, the Benefits Review Board held in *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-___ (BRB No. 05-0335 BLA) (Jan. 27, 2006) (*en banc*) that the parties are entitled to introduce only one reading of "other evidence" such as CT scans. For this reason, I have not considered Dr. Wiot's reading. Dr. Baker reviewed the February 2005 scan on behalf of the Claimant and said it was of suboptimal quality, and no particular reading could be made. CX 9.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction or restriction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one second (FEV_1), and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. Pulmonary function studies submitted by the parties in connection with the current claim were in accordance with the limitations contained in 20 CFR § 725.414 (2006). No bronchodilators were administered in any of the studies. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height[3]	FEV_1	FVC	FEV_1/	MVV	Qualify ?	Physician Impression
DX 11 08/19/03 Mettu	58 68"	3.05	5.55		14.4	No	Mild obstructive disease with decreased MVV. Invalid due to less than maximum effort per Dr. Vuskovich, EX 11. Results indicate probable normal functioning.
EX 7 02/03/05 Rosenberg	60 67"	3.25	3.91	83%	79	No	No obstruction, no restriction. No need for bronchodilator response.
EX 1 05/11/05 Broudy	60 67"	3.28	4.15	79%		No	Normal.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records are not subject to the limitations. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in

[3] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 67" to 68" I have taken the mid-point (67.5") in determining whether the studies qualify to show disability under the regulations. *None of the tests are qualifying to show disability whether considering the mid-point or the heights listed by the persons who administered the testing.

Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify ?	Physician Impression
CX 1	05/01/03	Appalachian Regional Hospital	33.9	86.0	No	Normal.
DX 11	**08/19/03**	**Mettu**	**30.7 30.9**	**90.5 104**	**No No**	**Per Dr. Vuskovich, EX 11, exercise study showing increased pO_2 with exercise is normal.**
CX 2	08/05/04	Appalachian Regional Hospital	35.0	81.0	No	Mild hypoxemia.
CX 4	01/07/05	Appalachian Regional Hospital	31.0	109.0	No	Moderate acute respiratory alkalosis.
CX 4	01/12/05	Appalachian Regional Hospital	34.0	71.0	No	Mild hypoxemia.
EX 7	**02/03/05**	**Rosenberg**	**33.9**	**90.3**	**No**	**Normal oxygenation.**
EX 1	**05/11/05**	**Broudy**	**36.1**	**77.9**	**No**	**Mild hypoxemia.**
CX 6	07/15/05	Appalachian Regional Hospital	36.0	84.0	No	Normal.
CX 8, CX 10	09/02/05	Appalachian Regional Hospital	35.0	79.0	No	Mild hypoxemia.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contra-indicated, total disability may be nevertheless found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions submitted in connection with the current claim.

Treatment Records

The Claimant was admitted to the hospital from May 1-5, 2003, under the care of Dr. Imtiaz Hussain, after complaining of severe breathlessness and pain on the right side of his chest. According to the American Board of Medical Specialties, Dr. Hussain is Board-certified in Internal Medicine and Pulmonary Disease. According to the NIOSH website, he is an A reader. On examination, the Claimant was dyspneic, and lung examination revealed bilateral scattered rhonchi with evidence of an exacerbation of his COPD. His admitting diagnoses included acute exacerbation of COPD, pneumoconiosis, right chest pain, and rule out pneumonia. He improved with treatment, and was discharged with final diagnoses of acute exacerbation of chronic obstructive pulmonary disease (COPD), history of hypertension, and cor pulmonale. CX 1.

The Claimant was again admitted to the hospital from August 5-13, 2004, after presenting with severe respiratory distress. Dr. Hussain was his attending physician. The Claimant complained of wheeze with cough, thick, mucopurulent expectoration, and chest tightness with smothering spells. On examination, he was dyspneic. Lung examination revealed bibasilar crackles and scattered rhonchi. His admitting diagnoses included acute exacerbation of COPD, black lung, and hypertension. He improved with treatment. His discharge diagnoses were acute exacerbation of COPD, hypertension, and osteoarthritis. CX 2.

The Claimant underwent another hospitalization under the care of Dr. Hussain from January 7-14, 2005. The Claimant presented to Dr. Hussain's office with severe breathlessness, complaining of wheeze with cough, thick mucopurulent expectoration, nausea, vomiting, and smothering spells. He was wheezing and using accessory muscles of respiration. He had

vesicular breathing, bibasilar crackles with scattered rhonchi and diminished breath sounds in both lung bases. Admitting diagnoses were acute exacerbation of COPD and hypertension. The Claimant was admitted and started on oxygen and medication. Chest x-ray did not reveal any infiltrates. He improved with medication and was discharged. His final diagnoses were acute exacerbation of COPD, hypertension, and chronic renal insufficiency. An inpatient progress note by Dr. Mansoor Mahmood dated January 11, 2005, assessed COPD and cor pulmonale. CX 4.

The Claimant was again admitted to the hospital from July 15-21, 2005, with Dr. Hussain as his attending physician. The Claimant presented to Dr. Hussain's office in respiratory distress. He complained of wheeze with cough and thick mucopurulent expectoration, and chest tightness with congestion and smothering spells. He had earlier been started on broad-spectrum antibiotics, but failed to respond to the medication. Dr. Hussain diagnosed acute exacerbation of COPD and hypertension, and admitted the Claimant to the hospital. He was given oxygen and medication, and gradually improved. His discharge diagnoses were the same as the admitting diagnoses. CX 6, 10.

The Claimant was next admitted to the hospital under the care of Dr. Hussain from September 2-9, 2005, again diagnosed with acute exacerbation of COPD and hypertension. His complaints, physical examination, and hospital course were similar to his previous hospitalizations. CX 8, 10.

Opinions Given in Connection with the Black Lung Claim

Dr. R.V. Mettu examined the Claimant on behalf of the Department of Labor on October 7, 2003. DX 11. According to the American Board of Medical Specialties, Dr. Mettu is Board certified in Internal Medicine and Pulmonary Disease. He took occupational, social, family, and medical histories, and conducted a physical examination. Chest x-ray, blood gas studies, and pulmonary function testing had taken place on August 19, 2003. Dr. Mettu reported that the Claimant worked in the mines for 27 years. He reported that the Claimant had never smoked. The chest examination was normal. The x-ray, read by Dr. West, DX 11 and DX 12, was negative, showing no evidence of pneumoconiosis. The pulmonary function test showed a mild impairment. The arterial blood gas study was normal. Dr. Mettu diagnosed chronic bronchitis caused by coal dust exposure and smoking. Dr. Mettu found that the Claimant had a mild impairment in function based on his lungs due to coal mine work.

On March 19, 2004, in response to an inquiry from the Department of Labor, Dr. Mettu submitted a letter supplementing his report to correct his error regarding the Claimant's smoking history. In the letter, he stated as follows:

> [The Claimant] did not have any history of smoking. He is a non smoker, and he never smoked. For some reason it was an oversight on my part to say that he smoked. He did work in the coal mines. By looking at the history it is my feeling that there was an oversight and a typing error. This gentleman did work in the coal mines. He has a mild pulmonary impairment most likely cause[d] by working in the coal mines. …

DX 11.

Dr. Hussain responded to three questionnaires from the Claimant's attorney. *See* DX 22 (response dated April 4, 2004), CX 3 (response dated December 8, 2004), and CX 7, CX 8, and CX 10 (three copies of the response dated August 25, 2005). On his Evidence Summary Form, the Claimant designated the responses dated December 8, 2004, and August 25, 2005, as the medical reports on which he wished to rely. I have, therefore, considered only the later two responses, and disregarded the April 4, 2004, questionnaire response. By checking the appropriate boxes on both forms, Dr. Hussain indicated that the Claimant has a chronic lung disease caused by his coal mine employment, which Dr. Hussain identified as legal, but not clinical, pneumoconiosis. On the August 2005 response, Dr. Hussain elaborated that the basis for his diagnosis was the Claimant's breathlessness, wheezing, cough, and impaired exercise tolerance. On the December 2004 response, Dr. Hussain indicated that coal dust significantly contributed to the Miner's condition, while on the August 2005 response, he said coal dust both significantly contributed to and aggravated the Miner's condition. Among four levels characterizing the extent of the Miner's pulmonary impairment, ranging from "no impairment" to "totally disabled," Dr. Hussain marked "totally disabled" on both forms. He said the impairment was related to pneumoconiosis, as opposed to having another etiology. He said that the Claimant did not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment due to severe dyspnea, on the earlier form, and due to breathlessness and dyspnea, on the later form. On both, he indicated that the condition related to coal mine employment has "a material adverse effect on the miner's respiratory or pulmonary condition." He also indicated that he had not prescribed home oxygen on both forms. Finally, he indicated that he had treated the Claimant from January 6, 2002, to date, on the earlier form, and from May 2, 2002, to today, on the later form. CX 3, 7, 8.

Dr. David Rosenberg examined the Claimant on behalf of the Employer on February 3, 2005. EX 7. Dr. Rosenberg is Board certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, CT scan, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 27 years. He reported that the Claimant had never smoked. The chest examination was normal.
Dr. Rosenberg read the x-ray as showing no evidence of pneumoconiosis. The CT scan was negative for any micronodularity, emphysema, or any form of interstitial lung disease. He re-read the x-ray after Dr. Baker read it to be positive, 1/0. *See* the table of x-ray readings above. He said that the x-ray was definitely negative for pneumoconiosis, which was supported by the negative CT scan. He said that the CT scan is a more accurate tool for diagnosing the presence of pneumoconiosis. The pulmonary function test was normal. Diffusing capacity corrected for lung volumes was mildly reduced, indicating some loss of the alveolar capillary bed. The arterial blood gas study was normal. Based upon his examination, Dr. Rosenberg concluded that the Claimant was not suffering from the "interstitial form" of coal worker's pneumoconiosis. From a functional perspective, Dr. Rosenberg said that the Claimant had no significant obstruction or restriction, with normal oxygenation. Dr. Rosenberg found that the Claimant had no significant impairment in function based on his lungs, and that he retained the respiratory capacity to perform his last job in the mines. He thought the Claimant's reports of recurrent respiratory infections could not be caused or hastened by the past inhalation of coal mine dust. Dr. Rosenberg requested that counsel for the Employer forward the Claimant's previous records to him when they were available.

Dr. Rosenberg reviewed the Claimant's medical records, including the reports from Dr. Mettu's examination and the Claimant's treatment records, and prepared a supplemental report dated October 31, 2005. EX 9. He observed that the Claimant had been admitted to the hospital for various respiratory flares, but his pulmonary function tests were persistently normal, without obstruction or restriction, blood gas was normal at the time of his evaluation, and chest x-ray and CAT scan revealed no micronodularity. He said the treatment records did not outline treatment for a medical form of coal workers' pneumoconiosis. He said that in the absence of any significant obstruction or restriction, the Claimant did not meet the clinical definition of COPD, which is based on a reduction of FEV_1 divided by FVC. He said that there was no evidence to conclude that past coal mine dust exposure, which ceased over 15 years before, was responsible for the Claimant's hospital admissions with various flares of bronchitis with recurrent infection. Thus, he disagreed with Dr. Hussain that the Claimant has legal pneumoconiosis. Based upon this review, Dr. Rosenberg concluded that the Claimant does not suffer from either medical or legal pneumoconiosis, and retains the ability to perform his last coal mine job or job of similar arduous work.

In a deposition taken on November 29, 2005, Dr. Rosenberg testified regarding his examination of the Claimant, and the records he reviewed. EX 10. Dr. Rosenberg said that the Claimant was being treated for asthmatic bronchitis. When he had respiratory flaring, with cough, sputum production, and shortness of breath, he was treated with bronchodilators, antibiotics and corticosteroids, indicating treatment for acute flaring of an airway condition. Dr. Rosenberg said that although coal mine dust exposure can cause airways disease, the reversible types of problems the Claimant has do not reflect a condition related to coal mine dust exposure. He also stated that the Claimant "has that significant functional impairment which would prevent him from performing his previous coal mine employment." EX 10 at 16. He went on to state that it is the Claimant's recurrent asthmatic bronchitis, which is a condition of the general public, and does not constitute legal pneumoconiosis, which would prevent the Claimant from working. Asked how he could say that the Claimant's condition was not caused by coal mine dust, he described the formation of macules and focal emphysema, evolving into micronodules, macronodules, and progressive massive fibrosis, resulting in fixed, rather than reversible, airways disease. Dr. Rosenberg said the Claimant's symptoms and findings of shortness of breath are real, but not related to coal dust exposure. He said that when he examined the Claimant, the Claimant appeared to be short of breath when he moved around. His heart rate increased with exertion. Dr. Rosenberg had no question that the Claimant has some airways disease, but said that the fact that he normalizes in between episodes means that his condition is not caused by or aggravated by past coal mine dust exposure.

Dr. Bruce Broudy examined the Claimant on behalf of the Employer on May 11, 2005. EX 1. Dr. Broudy is Board certified in Internal Medicine and Pulmonary Disease, and a B reader. He is also a Board-certified Medical Examiner. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, CT scan, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 27 years. He reported that the Claimant never smoked. The chest examination was normal. Dr. Broudy read the x-ray as showing no evidence of pneumoconiosis or silicosis. The pulmonary function test was normal, as were lung volumes and diffusing capacity. The arterial blood gas study showed mild resting hypoxemia. Dr. Broudy did not perform an exercise study because the Claimant was using a cane and could barely walk. Dr. Broudy diagnosed dyspnea, obesity and hypertension. Based upon his examination, Dr. Broudy concluded that the Claimant

was not suffering from coal worker's pneumoconiosis. Dr. Broudy found that the Claimant had no impairment in function based on his lungs, and that he retained the respiratory capacity to perform his last job in the mines. Additionally, Dr. Broudy opined that the Claimant did not suffer any chronic lung disease due to any cause.

On October 18, 2005, Dr. Broudy attached an addendum to his original report. EX 5. In the addendum, he reviewed medical evidence supplied to him by the Employer after his original examination of the Claimant, including the report of the October 2003 examination by Dr. Mettu, the report from Dr. Rosenberg's February 2005 examination, and records of hospital admissions in May 2003, August 2004, January 2005, and July 2005. Dr. Broudy said that there was

> … no evidence that the Claimant had any pulmonary disease including coal workers' pneumoconiosis or that he had any respiratory impairment. The admissions to hospital for exacerbations of COPD are curious since he never demonstrated any respiratory impairment on any lung function testing, either before or after these hospital stays. When I examined him in May, 2005, he also had normal lung function except for the very mild hypoxemia on blood gases. Spirometry, lung volumes and diffusion were normal and the chest x-ray was negative for pneumoconiosis. Also, the high resolution CAT scan of the chest on my exam was negative for pneumoconiosis.
>
> In summary, there is no evidence that this gentleman has coal workers' pneumoconiosis, silicosis or any respiratory disease due to the inhalation of coal mine dust. There is no evidence of any respiratory impairment due to any cause. The additional medical evidence only supports the conclusion I reached after my examination of May 11, 2005.

EX 5 at 5.

Dr. Broudy was deposed on December 2, 2005. EX 6. Dr. Broudy reiterated the opinion he gave at the time of the examination. On cross-examination he was asked to define COPD. He said it is a chronic disease with the major characteristic of airways obstruction, usually associated with pulmonary emphysema, chronic bronchitis, or chronic asthma. He said it can be caused by exposure to coal dust, as can cor pulmonale, which is right-sided heart failure due to lung disease, and hypoxemia, which is a reduction in the partial pressure of oxygen in the lung. He said that shortness of breath and wheezing , coughing, and sputum were chronic complaints of the Claimant. He again stated that the Claimant has no lung condition, or any impairment from a lung condition.

After the hearing, counsel for the Claimant sent Dr. Hussain his treatment records, his previous questionnaire responses, and the deposition transcripts of Drs. Broudy and Rosenberg. Counsel requested that Dr. Hussain review the materials he had sent, and indicate whether they changed his opinion regarding the Claimant's medical condition as set forth in his reports of August 25, 2005, and December 8, 2004, *i.e.*, by marking "yes" or "no" on the letter, and signing and dating it. Dr. Hussain marked "no," indicating that his opinion had not changed. The Employer did not object to the submission by the Claimant, which I hereby admit as CX 11.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

In this case, the Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. *Ibid.*; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("[t]he Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to

pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the available x-rays in this case, only one has been read to be positive for pneumoconiosis, and the rest, either negative, or there is no reference to pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

None of the Radiologists who interpreted the x-rays taken during the Claimant's medical treatment made any reference to pneumoconiosis. Whether an x-ray interpretation, which is **silent** as to pneumoconiosis, should be interpreted as **negative** for pneumoconiosis, is an issue of

fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). As all of the Radiologists found some abnormality, *i.e.*, atelectasis on the May 2003 x-ray and chronic obstructive pulmonary disease on all of the others, I find that none should be interpreted as negative for pneumoconiosis.

As to x-rays read in connection with the black lung claim, the earliest x-ray, taken on August 19, 2003, has been read as negative by two dually qualified readers, Dr. West and Dr. Wiot. There are no positive readings. I find this x-ray to be negative for pneumoconiosis.

The x-ray taken on February 3, 2005, has been read as positive by Dr. Baker and negative by Dr. Rosenberg. Both are B readers. This x-ray is in equipoise and, therefore, neither positive nor negative.

The x-ray taken on May 11, 2005, has been read as negative by Dr. Broudy, a B reader. There are no positive readings. I find this x-ray to be negative for pneumoconiosis.

As there are no positive x-rays, the Claimant cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

The CT scans were also negative for pneumoconiosis. Like negative x-rays, however, negative CT scans do not rule out the presence of pneumoconiosis, especially legal pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a Judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105

(1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that

> … in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted). In this case, the Claimant identified Dr. Hussain as his current treating physician.

Dr. Hussain is a Pulmonologist and has been treating the Claimant since 2002. Treatment records indicate that the Claimant was hospitalized once in 2003, once in 2004, and three times in 2005, for severe breathing problems. Each time, after medical treatment, the Claimant was released with his symptoms improved. Dr. Hussain consistently diagnosed COPD and black lung, and in response to the Claimant's counsel's questionnaires, characterized the Claimant's chronic lung disease as legal pneumoconiosis, and attributed it to exposure to coal dust. I find that Dr. Hussain's opinion is documented and reasoned, as it is based on his treatment of the Claimant over a three-year period, and it is, therefore, entitled to probative weight on the issue of pneumoconiosis. However, I cannot give it controlling weight, as I cannot determine the basis for his diagnosis of COPD in the absence of evidence of obstruction on pulmonary function testing, or any explanation from Dr. Hussain as to why he made the diagnosis, even after he reviewed the opinions of Drs. Broudy and Rosenberg.

Dr. Mettu, who examined the Claimant on behalf of the Department of Labor, is also a Pulmonologist. He diagnosed chronic bronchitis and, as the Claimant is not a smoker, he attributed the diagnosis to exposure to coal dust. I find this to be a diagnosis of legal pneumoconiosis. Dr. Mettu took relevant histories, conducted a physical examination, and performed objective tests. His opinion is supported by the evidence available to him. I find that his opinion was documented and reasoned. I give it some probative weight on the issue of whether the Claimant has pneumoconiosis. However, his opinion is flawed because his diagnosis was based at least in part on an invalid pulmonary function test.

Dr. Rosenberg, too, is a Pulmonologist. In addition to examining the Claimant, he also had the opportunity to review Dr. Mettu's report and the Claimant's treatment records. He diagnosed asthmatic bronchitis, with periodic flares requiring hospitalization. He confirmed that the Claimant's symptoms and shortness of breath were real, *i.e.*, that the Claimant has airways disease. However, he said the fact that the Claimant's problems are reversible means that they were not caused by coal dust exposure. Dr. Rosenberg pointed out that the Claimant does not meet the clinical definition for COPD, as he does not demonstrate the requisite reduction of the ratio between his FEV_1 and FVC. However, confidence in Dr. Rosenberg's opinion is

undermined, because he gave contradictory opinions on whether the Claimant is disabled. Nonetheless, I also find that Dr. Rosenberg's opinion on the presence of pneumoconiosis is documented and reasoned, and give it probative weight.

Finally, Dr. Broudy, also a Pulmonologist, like Dr. Rosenberg, had the opportunity to both examine the Claimant, and to review his records. Dr. Broudy found no chronic lung disease of any kind. He characterized the Claimant's hospital admissions as "curious," as the Claimant never demonstrated impairment on objective testing, other than mild hypoxemia on his blood gases. I find that his opinion on the issue of the presence of pneumoconiosis is not well reasoned because it is incomplete, as he gives no diagnosis or explanation for the Claimant's repeated hospitalizations and treatment for airway disease.

The evidence in this case is particularly troubling because of the seeming contradiction between the Claimant's recurrent symptoms and hospitalizations, generally normal functional objective testing, and flawed medical opinions on both sides of the issue. Although Dr. Hussain was in the best position to evaluate the Claimant's condition as his treating physician, he offered no explanation of his rationale for concluding that the Claimant's lung problems are due to coal dust. Moreover, when presented with the contrary opinions of Drs. Rosenberg and Broudy, Dr. Hussain did not offer any explanation as to why his opinion remained unchanged. Nor did he offer any explanation as to why their opinions were mistaken. Confidence in his opinion is also undermined by his diagnosis of obstructive disease, when no obstruction is apparent on pulmonary function testing, and by his assessment of total disability, without any explanation of the nonqualifying pulmonary function and arterial blood gas studies. Dr. Mettu's opinion that the Claimant has legal pneumoconiosis appears to rest largely on his view that pulmonary function testing showed an obstructive impairment. However, the pulmonary function tests on which he based that opinion have been invalidated, and, in any event, more recent pulmonary function tests resulted in normal values. In the final analysis, I conclude that the opinions of Dr. Hussain and Dr. Mettu are insufficiently explained and reasoned to carry the Claimant's burden of establishing that he has pneumoconiosis. Dr. Rosenberg's opinion on this issue is more thoroughly explained, is supported by the objective medical evidence of record, and is, therefore, entitled to more weight. Thus, I find that the Claimant has failed to establish the presence of pneumoconiosis on the basis of the medical opinion evidence.

Neither the x-ray evidence, nor the CT scans, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal mine dust. Thus, he cannot show that he is entitled to benefits under the Act.

Total Pulmonary or Respiratory Disability

Even were I to find that the Claimant had established that he has pneumoconiosis, his claim would still fail, because he has not established that he is totally disabled by a pulmonary or respiratory impairment.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause and which prevents him from doing

his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis. Thus, I will consider pulmonary function studies, blood gas studies, evidence of cor pulmonale, and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

None of the pulmonary function studies or arterial blood gas studies resulted in values qualifying for disability. Dr. Vuskovich, who reviewed the results of the pulmonary function and arterial blood gas studies from August 19, 2003, said that, based on their results, the Claimant had the pulmonary capacity required for coal mine employment. EX 11. Later testing revealed even better functioning than in 2003. Moreover, although at least two of the Claimant's hospital records include a diagnosis of cor pulmonale, in May 2003 and January 2005, there is no further mention of the diagnosis in later records, nor any objective findings supporting the diagnosis. Thus, I find that the record does not support a finding of disability based on objective testing or cor pulmonale.

As to the medical opinions, only Dr. Hussain said consistently, in responding to the questionnaires, that the Claimant has a pulmonary or respiratory impairment which is totally disabling, based on breathlessness and dyspnea. However, Dr. Hussain's conclusory statements did not address the nonqualifying results of the pulmonary function and arterial blood gas testing; nor did he respond to the observations by both Dr. Broudy and Dr. Rosenberg that despite recurrent hospitalizations, testing of the Claimant's functional capacity always returned to normal values. As Dr. Hussain did not explain his rationale for his opinion that the Claimant is disabled, I cannot find it to be a reasoned opinion.

Dr. Mettu stated only that the Claimant has a mild impairment. I do not infer from this that he thought the Claimant would be disabled from working by a mild pulmonary impairment. In any event, I have found that his view that the Claimant has an obstructive impairment is not supported by the objective evidence. As a result, his opinion on disability is not material to the outcome.

Dr. Rosenberg contradicted himself on this issue, stating in his initial report, that the Claimant is not disabled, but stating during his deposition that the Claimant is disabled. He did not explain the about-face and, therefore, I give little weight to his opinion on this issue.

Despite Dr. Broudy's incomplete analysis on the issue of whether the Claimant has pneumoconiosis, I find that his opinion that the Claimant is not disabled by a pulmonary or

respiratory impairment is supported by objective evidence. Thus, I afford his opinion the most weight on this issue.

I find that the preponderance of medical opinion evidence does not support a finding of total disability.

Finally, weighing like and unlike evidence together, the preponderance of all of the evidence does not support a finding of total disability. None of the pulmonary function tests or arterial blood gas studies resulted in qualifying values. Nor does the record support a finding of cor pulmonale. The weight of the medical opinion evidence supports the conclusion that the Claimant has no persistent pulmonary or respiratory impairment, despite his periodic hospitalizations.

Although the Claimant has said that he has been unable to work since August 1988, *see* DX 5 at 2, and that he cannot work in the mines any more due to his breathing, DX 1 at 1707, 1718, I cannot base a finding of disability solely on his testimony. I find that the opinion of Dr. Broudy, that the Claimant does not have a pulmonary or respiratory impairment, is consistent with the weight of the medical evidence as a whole, including the pulmonary function and arterial blood gas studies. Thus, I conclude that the Claimant has failed to establish that he is totally disabled by a pulmonary or respiratory impairment.

Because the Claimant has not established either that he has pneumoconiosis or that he is totally disabled by a pulmonary or respiratory impairment, he cannot establish any of the essential elements for entitlement to benefits.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that one of the applicable conditions of entitlement has changed since the denial of his previous claim became final, or that he has pneumoconiosis, or that he is totally disabled due to pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by the Claimant on July 17, 2003, is hereby DENIED.

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ALICE M. CRAFT

Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's Office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).